White Paper

New Hampshire Insurance Department
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The Small Group Health Insurance Market

I. Background

A. The small group market rules under SB 711 (passed in 1994):

1. Small groups were defined as employer groups with 1-100 employees.

2. Groups were rated up or down from the average or community rate based on the age of the employees. The maximum permissible variation allowed under the age rating factor was 3 to 1; that is, the rate for the highest rated employee based on age could not exceed the rate of the lowest rated employee by more than 300%.

3. Groups were rated up or down from the average or community rate based on the size of the group with a maximum permissible variation of 20% or 1.2 to 1.

4. The following consumer protections were put in place: guaranteed issue[1], guaranteed renewability[2], portability[3], and limitations on preexisting condition exclusion periods.[4]

B. Chapter 296 (2001 Session) limited open enrollment for groups of one to the months of April and October.

C. Changes to the market rules under SB 110 (passed in 2003):

1. The definition of small group was changed from 1-100 to 1-50.

2. The rating factor for age was changed from 3:1 to 4:1.

3. A rating factor for geographic location of 15% or 1.15:1 was introduced.

4. A rating factor for industry classification of 20% or 1.2:1 was introduced.

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[1] No group may be denied insurance from any insurer selling in the small group market, and all products must be actively marketed to all groups.

[2] Once a health policy is purchased, the insurer is generally required to renew the policy at the option of the insured.

[3] Anyone with a preexisting condition who changes employers and therefore insurers shall have his or her period of coverage with the previous carrier applied as a credit against the succeeding insurer's preexisting condition exclusion period.

[4] Benefits must be provided for all preexisting conditions for an insured whose policy has been in effect for at least 9 months.

5. A rating factor for health status of 67% or 1.67:1 was introduced.

6. A rating factor for self-employed persons (groups of one) that is essentially an add-on to the existing 20% factor for group size was introduced. This factor allows insurers to rate up groups of one by an additional 10%.

7. Limits were placed on premium increases that small groups could experience at renewal:

    a. Increases solely attributable to changes in the health status factor are limited to 15%.

    b. During a transition period that ends January 1, 2005, increases that are solely attributable to the combined effect of health status, geographic location, industry classification, and status as a group of one are limited to 25%.

8. SB 110 did not change the requirements of guaranteed issue, guaranteed renewability, portability, and limits on preexisting condition exclusion periods. However, the change in the definition of the small group market eliminated those protections for employers that had over 50 employees. Previously those protections applied to employers having between 50 and 100 employees.

9. The market rules under SB 110 require the use of a health statement form for rating purposes. Previously, because the law did not allow carriers to consider the health status of the group in calculating the premium, the use of health statements was prohibited.

10. The combined effect of the existing rating factors and the new rating factors introduced in SB 110 resulted in a permissible rate variation between the highest and lowest rated group of 12.2:1. Under SB 711, the maximum permissible variation was less than 3.6:1.

11. SB 110 substantially changed the distribution of insurance premiums among the employer groups in the small group market. Generally, smaller groups that had older or sicker employees paid more and larger groups with younger and healthier employees paid less.

II. Basics of Insurance Rate Regulation and Market Rules

Does the state have plenary authority to regulate the small employer group health insurance market?

No, the state health insurance market is regulated in some respects by federal law. Generally, the federal government regulates the conditions and terms of a carrier's sale of a

health insurance plan to a small employer, while the state regulates the pricing of the insurance plan or product. Increasingly, small employers are choosing to self-fund their employee health insurance benefits by opting to insure a certain amount of the funding risk with a stop-loss carrier. The state has little authority over the products or how they are sold.

What specific aspects of the health insurance market are regulated by federal law?

Federal law sets the minimum standards for the regulation of the small employer group market, and requires that carriers make coverage available to all small group employers. Federal law does not establish any price controls or pricing rules for that coverage.

How does federal law impact the state's ability to define the small employers that are eligible to participate in the small group market?

Federal law requires that the small group market include employer groups include all small employer groups that have between 2-50 employees. Under existing law, New Hampshire defines the small group market as including employer groups having between 1-50 employees.

What is the impact of adding larger small employer groups?

Larger small employer groups—groups having between 50-100 employees-- have a greater ability to self-insure when the group is healthy. Adding these groups to the small employer group market presents some potential for adverse selection and may potentially reduce the quality of the risk pool.

What is the impact of having groups of one in the market?

Groups of one enjoy guaranteed issue of an insurance product with more comprehensive coverage than what would be otherwise available in the individual market, thereby creating an adverse selection risk. Groups of one have been included in the small group market since 1994.

What specific aspects of the health insurance market are regulated by state law?

For fully insured products, state market rules control how insurance is priced and determine the distribution of premium rates within the state. State law also controls what carriers may consider in determining premium rates. For stop loss products, state market rules do not apply.

How do state market rules affect the distribution of premiums?

The distribution of premium rates can be affected both by prospective rating rules that allow a carrier to adjust a premium in advance of a sale based on certain case characteristics or retrospective rules that provide rating protection or premium relief after the point of sale.

What are the policy goals of state market rules?

The policy goals of market regulation are to limit the variability in health insurance costs among small employer groups, to promote a competitive market, and to minimize barriers to entry. Public policy goals are often conflicting, and the resolution of the policy goals rests with the legislature.

What are state market rules and how are they used in pricing health insurance?

Market rules include rating restrictions and other rules governing how insurance is issued and marketed. State market rules govern how insurance is rated and determine how premium costs are distributed across the market. Rating rules allow or prohibit a carrier from using certain case characteristics as well as health to adjust the amount of premium charged to different groups. Case characteristics can include non-discretionary and discretionary factors. Non-discretionary factors are those case characteristics such as gender, age, group size, industry and geography that a carrier applies based upon a pre-determined weighting formula. By contrast, health is a discretionary factor that a carrier applies to rate a group based on its own underwriting criteria. As applied by the carrier in setting premium rates for different groups, rating rules that allow the use of health as a discretionary factor differ substantially from those that do not.

What issues should be considered in setting rating restrictions?

The first issue that must be addressed in establishing rating restrictions is whether to allow carriers to use a discretionary factor to establish premium rates, or whether to allow carriers to apply only non-discretionary factors in setting premium rates. If the rules allow the use a discretionary factor in setting premium rates, a decision must be made as to the extent of health information that a carrier will be allowed to collect before rating and issuing a policy of group insurance.

In deciding how much difference there should be in the premium charged for the same coverage to different groups, what factors should be considered?

The rating rules will determine the amount of premium that a carrier can charge to an employer group for a certain type of benefit plan. The rating rules create an artificial relationship between a group's expected health utilization and premium costs. The more restrictive the rating rules are regarding a carrier's ability to adjust the amount of premium charged by the case characteristics of the employer group, the more attenuated the relationship becomes between expected health utilization (claims costs) and the premium charged. Low risk groups are charged considerably more than the amount of their expected claim costs, and high-risk groups are charged considerably less than the amount of the expected claim costs. As the relationship between expected claims costs and utilization becomes more attenuated, the risk of adverse selection against the market increases.

How do rating rules affect the amount of premium that can be charged to a small employer?

Rating rules generally allow a carrier to use certain case characteristics of the group in setting a premium. These case characteristics are referred to as rating factors. Rating factors fall into two groups: non-discretionary factors that are applied according to an established formula, and discretionary factors, that a carrier applies according to its own underwriting criteria. Non-discretionary factors include age, group size, geography, and industry. Health status when allowed is a discretionary factor. Rating rules often place a limit on the weight that a carrier can apply to each rating factor, or limit the weight that a carrier may vary the premium of the group based on the application of a discretionary factor. Alternatively, rating rules may set a rating band that limits the total variation in premium that a carrier may charge, instead of placing a limit on the individual discretionary or non-discretionary rating factors.

How does a non-discretionary rating factor, or case characteristic, differ from a discretionary rating factor?

Even when limits are placed on the variance allowed by individual factors, the discretionary factor of health gives a carrier greater latitude to vary premium than the application of non-discretionary factors. In comparing different rating rules, the key distinguishing factor among different types of rating restrictions is the degree to which a carrier is able to reflect characteristics associated with expected utilization in its premium rates.

What types of rating rules do not allow a carrier to use a discretionary factor?

There are several types of rating rules that do not allow a carrier to use a discretionary factor in setting the premium rate for a small employer group. These rating rules are generally referred to as pure community rating and adjusted community rating. Pure community rating allows a carrier to adjust premiums based only on the benefit package and family size. Pure community rating does not reflect differences of expected utilization among different groups. Instead, the higher costs of less healthy groups are spread across all coverage groups. Spreading these costs to all groups creates a risk of adverse selection because healthy, younger groups may elect to opt out of the market. When younger, healthier groups leave the market, the quality of the risk pool declines and the overall costs in the market increase. Adjusted community rating allows a carrier to adjust premiums based on the benefit package, family size, and other allowable non-discretionary factors, such as age, group size, industry, or geography. Adjusted community rating attempts to adjust the premium rates so that the better risks pay less for coverage and do not elect to leave the market.

What types of rating rules allow a carrier to use a discretionary factor?

There are several types of rating rules that allow a carrier to use a discretionary factor to vary the premium rates charged for the same coverage to different small employer groups. The health status factor is a discretionary factor, and the carrier is not limited to a formulaic application of this factor. If the carrier determines that the group represents a health risk based

on the health status of a member of the group, the carrier can apply a health status factor to adjust the overall premium charged to the group based on the health of one of the members of that group. Rating rules that allow discretion generally place a limit on the extent to which a carrier can vary premium to reflect the health status and case characteristics of the group.

What is a composite rating band?

A composite rating band establishes the maximum allowable variation in premium rates that a carrier may charge using all the permitted rating factors. Composite rating bands allow a carrier to exercise discretion in weighting factors, but limit the discretion by establishing a maximum allowable amount of variation. Unless the allowable rating factors include the discretionary factor of health, the use of a composite band is not warranted due to the lack of discretion available to the carrier in the application of the underlying non-discretionary factors.

How does the allowed amount of variation affect the operation of the small employer market?

The distribution of premium in the small employer group market is determined by the allowable variation permitted by the rating laws. In determining the degree of variation that should be allowed by the rating rules, consideration should be given to the following: the potential risk of adverse selection against the market, the willingness of carriers to write coverage without having the ability to risk select or risk adjust, and the possibility that lower risk groups will move out of the regulated market to access a better rate.

What is a health statement?

A health statement is a form used to collect health information from employees in order to provide the carrier with information sufficient to vary the premium to reflect expected use of health services. The legislation may prescribe the type of health statement that a carrier may use, and thus may limit the specific health information that a carrier may consider in setting the premium for the group. For example, the legislation might require a standardized health statement that provides limited information such as a diagnosis of a specified disease or condition, or the legislation could permit a carrier to use its own health statement to collect health information in advance of issuing a policy. A limited health statement might reduce administrative cost; make it easier for employer groups to obtain premium quotes, and make it easier for employer groups to shop for insurance. On the other hand, a limited health statement might reduce a carrier's interest in participating in the market, and make it more difficult for a carrier to fully exercise its underwriting judgment in writing insurance.

What methods are available to address concerns about market stability and barriers to market entry?

Under federal law, a carrier cannot refuse to sell health insurance to a small employer group. To mitigate the impact of the guaranteed issue requirement on carriers, some states provide an administered reinsurance mechanism. This mechanism allows carriers to reinsure

any risks that they believe will generate claim costs substantially in excess of the allowable premium. A reinsurance mechanism encourages carriers to transfer their highest risks to an industry funded pool, reduces the carrier's incentive to risk select in the market, and minimizes the risk of adverse selection against the carrier.

How can the distribution of premium costs be changed?

The distribution of premium costs in the small group market can be changed by amending the rating factors or by adopting a mechanism that provides retrospective rating relief. The options for affecting distribution of rates include repealing rating factors or changing the weight assigned to those factors, adopting community rating or adjusted community rating, or instituting a composite band to limit rate variability.

What mechanisms are available other than rating rules to adjust the distribution of premium costs in the market?

The distribution in premium costs can be adjusted using retrospective rating or premium adjustment. A premium subsidy mechanism, that collects money from a third party source and redistributes that money in the market, could effectively limit the amount of premium an employer group will pay for certain coverage. This allows the use of less restrictive rating, while at the same time limiting the variance in premium costs.

What mechanisms are available to reduce barriers to market entry and to enhance market stability?

An administered reinsurance mechanism that allows a carrier to cede certain individuals or risks to a reinsurance pool reduces the risk posed to a carrier by the requirement of guarantee issue. A market mechanism spreads risks throughout the market. By redistributing funding for certain risks throughout the market, a reinsurance mechanism enhances market stability by mitigating the impact of catastrophic claims on smaller carriers in the market. Under guarantee issue, and rating rules that restrict a carrier's ability to set a premium that reflects the actual expected claim costs, a carrier can neither reject a risk nor price that risk to protect itself financially. A reinsurance mechanism provides protection to the carrier by allowing the carrier to cede high risks to the mechanism. In order to know which risks to cede, a reinsurance mechanism requires the collection of health information through the use of a health statement.

How does a reinsurance mechanism differ from a high-risk pool?

A reinsurance mechanism differs from a high-risk pool because reinsurance is invisible to the reinsured risk. Under a reinsurance mechanism, a carrier may elect to cede the risk of an individual who is in a small employer group. The carrier pays a premium to the pool, and the losses in excess of the premiums received by the pool are covered by an assessment. The individual whose risks are ceded to the pool retains coverage as part of the small employer group and is not aware of the risk ceding.

Why can't a high-risk pool be used as a market mechanism for the small group market?

Federal law effectively prohibits the use of a high-risk pool for the small group market.

What decisions must be made in setting up a reinsurance mechanism?

In setting up a reinsurance mechanism, decisions must be made regarding what risks may be ceded, when ceding will occur, the premium for ceding risks, how reinsurance coverage will be provided, the source of funding for excess claims, and the degree to which the ceding insurer should continue to bear the costs of the ceded risk.

III. The Policy Goals of Small Group Regulation

Here are some of the policy goals of small group regulation. There are often conflicts between these goals. Resolution of the conflicting policy goals rests with the legislature.

- Preserve access to affordable coverage for high-risk groups
- Avoid pushing the low risk groups out of the market
- Limit the variability in health insurance costs among small employer groups
- Minimize the difference between the rules governing the small group market and contiguous markets so as to avoid adverse selection against the regulated market
- Ensure adequate rate stability
- Reduce barriers to market entry
- Promote competition in terms of:
    - Number of insurers in the market with market share
    - Choice of products
    - Ability of consumers to comparison shop based on price
    - In general, promote the kinds of competition that are most beneficial to consumers
- Preserve a stable regulatory environment (minimize radical changes in market rules)
- Implement specific social values about fairness—e.g. people should not have to pay more just because they get sick, or people should take more responsibility for their own health care costs.

IV. The Unique Importance of Health Status in Market Rules

- Health status is the best indicator of expected utilization and claims costs.
- The decision of whether to allow health status will determine the process that small employer groups will use to purchase insurance.
- As a discretionary factor, health status has more impact on the amount of premium than any other factor, or in most cases, the combined effect of other non-discretionary factors.

- A composite band as a rating limitation is most effectively used with a health status factor.
- The decision is to use a health status factor in the single most important determination in crafting market rules, and has the greatest impact on the employer in the purchase of insurance and the carrier in the pricing and sale of insurance.

V. The Decision Process

Decision 1: Should carriers be allowed to exercise discretion to vary the premiums charged to small employer groups based on the health of that group?

- Health status is the best indicator of expected utilization and claims costs.
- Prohibiting a carrier from considering health in setting the premium for health insurance might keep some small insurers out of the market and make the small employer group market less competitive in terms of the number of insurers and choice of products.
- The use of a discretionary factor provides a carrier more latitude in rating than the use of non-discretionary factors.
- Allowing a carrier to vary the premiums of small employer groups based on health status may promote risk selection, and encourage carriers to compete only for the good risks.
- Without the use of a discretionary factor, employers will have a better sense of product costs before committing to a carrier. This will make it easier for employers to shop and might promote competition among carriers based efficiency, provider networks, and negotiated contracts.
- The use of health statements is administratively burdensome and makes it difficult for small employers to shop for insurance, or change carriers.
- Allowing the use of a discretionary factor in rating makes it more difficult for employers to get firm quotes because carriers do not want to perform underwriting of the group until all eligible employees have committed to the purchase of insurance.
- There may be less variety of insurance products available in a market with fewer carriers.
- Prohibiting a carrier from varying a premium based on the health of the small group may cause the healthier small employer groups to leave the market. Younger and healthier groups can self-fund and buy stop loss insurance. The exit of these groups from the market reduces the quality of the risk pool and increases the overall cost of insurance in the fully insured market.
- Stop-loss carriers that write coverage for small employer groups that self-fund collect and consider health information. Market rules that are not consistent across the different markets may result in risk segmentation between the fully insured and self-insured markets, and trigger an adverse selection spiral against the fully insured market.

Decision 2: What factors, or case characteristics, should be considered in varying the premium charged to different employer groups, and how much variation should be allowed?

- Tight variation causes the rates for the best risks to increase and the worst risks to decrease. Loose variation has the opposite effect.
- If the variation is too tight, the best risks may leave the market and go to the self-insured market, resulting in adverse selection that can lead to a market death spiral. If the variation is too loose, the price of insurance becomes prohibitively high for those who have the greatest need for insurance.
- Certain case characteristics of different groups have been shown to correlate with claims costs. These case characteristics include age, gender, geography, group size, and industry. These case characteristics are referred to as non-discretionary factors.
- Varying the premium charged to different groups based on the application of rating factors, both discretionary and non-discretionary, better approximates the expected health claims of the group.
- The application of rating factors, or case characteristics, to small groups generally results in increasing the cost of health insurance for those who need it most, and lowering the cost for those who are less in need of health insurance.
- Carriers determine rates by assigning a particular adjustment factor to a case characteristic. To determine the amount of allowed variation in the premium costs the rating factors are generally multiplied by one another. States limit the variation by limiting the allowed variation on individual rating factors or limiting the variation of their product, or a combination of both.
- The total variation allowed may be limited by placing a composite rating band on the factors. Generally when a composite rating band is used, specific limits are not placed on the underlying rating factors.
- The use of a composite band places a defined and expected limit on the allowed rating variation by prohibiting a carrier from charging a premium to a small employer group that exceeds the limit of the composite rating band.
- If the rating scheme does not limit the variation to a level deemed desirable for social purposes, the impact of the variation on high-risk groups can be mitigated through the use of a premium subsidy. A premium subsidy uses an assessment mechanism to reimburse high cost groups.
- If the rating scheme places tight limits on rating flexibility, the tendency to drive the good risks out of the market into self-insurance can be limited by regulating the types of coverage offered in the stop loss market. The NAIC has a model law regulating stop loss coverage that is designed to serve as a companion to small group market rules that limit rate variability.

Decision 3: Should there be limits on rate increases at renewal, either permanently or on an interim basis, to limit rate shock?

- Any change in rating rules produces winners and losers.

- If the changes are significant, then, absent transition rules, there will be groups that experience significant rate increases.
- Rate stability is important.
- Imposing caps on the amount by which a group's rate can be increased at renewal can limit the effect of changes in the rating rules.
- It is important to consider which factors that influence a rate are being left out of a cap.

Decision 4: Does the market require a mechanism to reduce barriers to entry for new insurers and stabilize costs to carriers?

- Federal law, HIPAA, prohibits a carrier from refusing to sell insurance to any small employer group. A market mechanism allows carriers to spread risks across the market that they cannot reject or price adequately.
- The tighter the allowed variation under the rating rules, the less the carrier is able to price the insurance to reflect the expected claims costs. Tight rating restrictions increase the need for a market mechanism.
- A reinsurance mechanism is blind to both the employer and the employee.
- The premiums paid by carriers into the reinsurance mechanism are generally insufficient to cover the claims paid by the reinsurance mechanism. Money to pay the cost of the excess claims must be raised from another source, which is generally an assessment against the market segment, e.g. the small employer group market.
- The use of an assessment to fund the excess claims costs redistributes the liability for catastrophic risks across the market, and protects smaller carriers from catastrophic claims for which they have not collected sufficient premium.
- Depending on the amount of premium charged to carriers for ceding risks to the reinsurance mechanism, the reinsurance mechanism can also be used to provide premium rate relief to high cost groups. A low ceding premium is likely to effect reductions in the premiums charged to the highest cost groups of between 5 and 15 employees.
- If the primary purpose of the market mechanism is to enhance market stability and reduce barriers to market entry, the amount of the ceding premium should correspond to the rating restrictions. The ceding premium should increase as the rating restrictions on carriers increase.